

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

442

**1. PLACE OF DEATH**

County Buchanan

Registration District No. 85

Township St Joseph Mo

Primary Registration District No. 1901

City St Joseph Mo (No. State Hosp 2)

File No. 23251

Registered No. 757

St.

Ward)

**2. FULL NAME**

(a) Residence, No. 1825 Cedar St. Mo

(Usual place of abode)

Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

M

**4. COLOR OR RACE**

Caucas

**5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)**

Single

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF**

**6. DATE OF BIRTH (MONTH, DAY, AND YEAR)**

About 1877

**7. AGE**

YEARS

MONTHS

DAYS

If LESS than 1 day, ..... hrs. or ..... min.

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**OCCUPATION**

**8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.**

Partner

**9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.**

**10. Date deceased last worked at this occupation (month and year)**

**11. Total time (years) spent in this occupation**

**12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)**

No. Unknown

**FATHER**

**13. NAME**

Madison Fisher

**14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)**

No. Unknown

**MOTHER**

**15. MAIDEN NAME**

Unknown

**16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)**

Unknown

**17. INFORMANT (ADDRESS)**

State Hospital Records

**18. BURIAL, CREMATION, OR REMOVED**

PLACE Blue Hill Farm DATE 7/6/1934

**19. UNDERTAKER (ADDRESS)**

St Joseph & Son Kansas City Mo

**20. FILED**

7-2-1934 John H. Bender Registrar

**MEDICAL CERTIFICATE OF DEATH**

**21. DATE OF DEATH (MONTH, DAY, AND YEAR)**

July 2, 1934

**22. I HEREBY CERTIFY that I attended deceased from**

Apr 8, 1934, to July 2, 1934

I last saw him alive on July 2, 1934 Death is said

to have occurred on the date stated above, at 4:30 p.m.

The principal cause of death and related causes of importance were as follows:

Pneumonia Date of onset 7-1-34

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**Other contributory causes of importance:**

San. Vases Indefinite

**23. If death was due to external causes (violence), fill in also the following:**

Name of operation no Date of no

What test confirmed diagnosis? Ex. Exam Was there an autopsy? no

Accident, suicide, or homicide? no Date of injury no

Where did injury occur? no (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury None

Nature of injury None

24. Was disease or injury in any way related to occupation of deceased? No

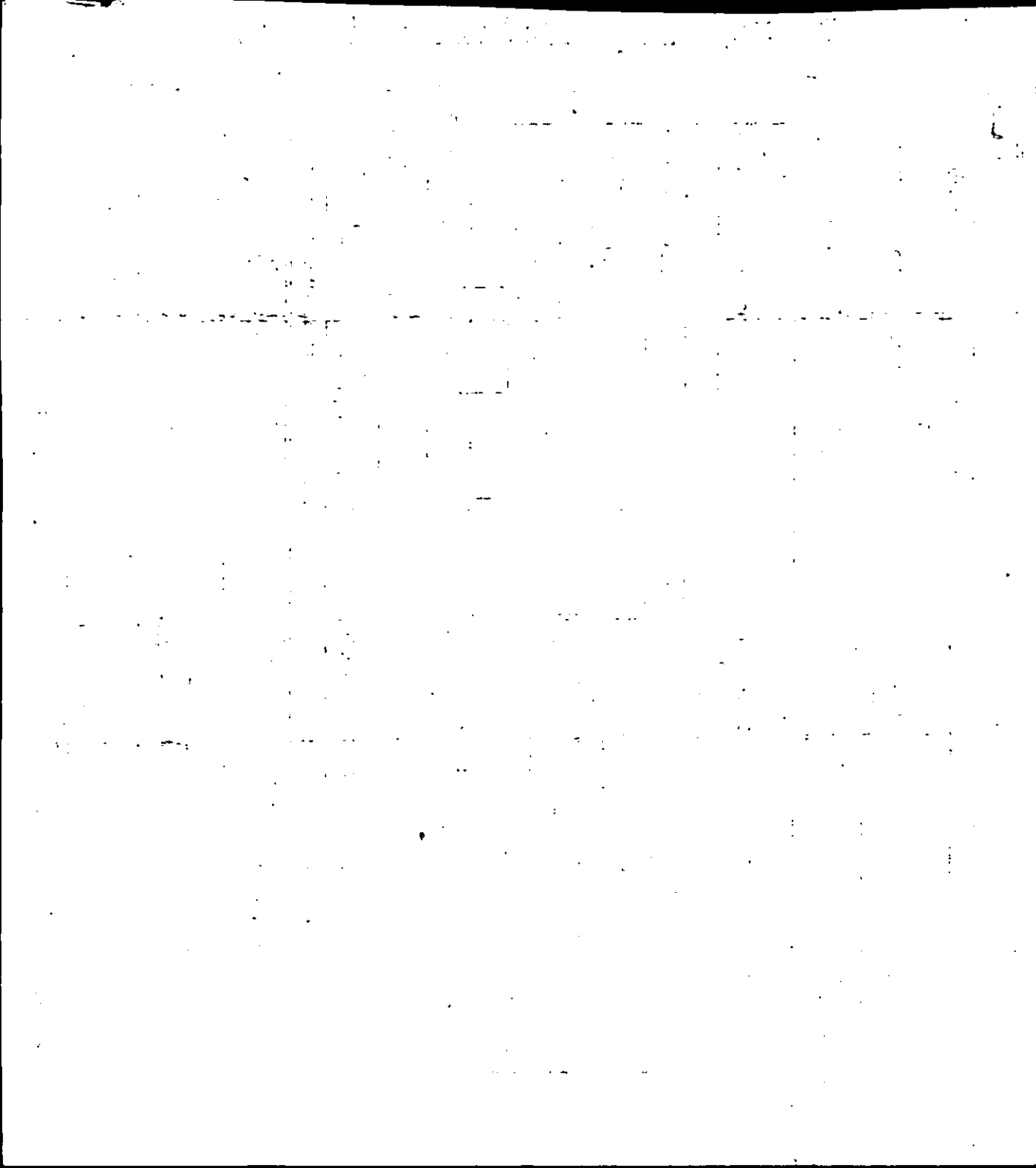
If so, specify no

(Signed) W. H. Miller M. D.

(Address) St Joseph Hosp No 2

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

AUG 14 1934



WASHINGTON

23251

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Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: William Fisher  
Who died at \_\_\_\_\_ on July 2 - 1934  
Residence: No. \_\_\_\_\_ St. \_\_\_\_\_  
(If nonresident, city or town).

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Sex m Color or race B Single, married, widowed or divorced: \_\_\_\_\_

Date of birth \_\_\_\_\_ Age: Years ad 57 Months \_\_\_\_\_ Days \_\_\_\_\_

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month \_\_\_\_\_ Year \_\_\_\_\_

Birthplace (State or country) \_\_\_\_\_

Birthplace of father (State or country) Gen. Pareses of Indiana

Birthplace of mother (State or country) syphilitis

Principal cause of death: \_\_\_\_\_

Other contributory causes of importance \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

Name of physician Dr. Miller

Address of physician State Hosp # 2

Signature of Registrar John R. Bender Date filed \_\_\_\_\_

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

Reg. Dist. No. 85

E. T. McGaugh

State Registrar

Primary Reg. Dist. No. 1001

Special Agent.

S-23251